GENERAL STATEMENT

	FY 2000 Actual	FY 2001 Appropriation	FY 2002 Estimate	2002 Est. +/- 2000 Actual	2002 Est. +/- 2001 Approp.
Health Services	$2,074,168,000	$2,265,663,000	$2,387,014,000	+$312,846,000	+$121,351,000
Facilities	316,555,000	363,103,000	319,795,000	+$3,240,000	-$43,308,000
Total, Budget Authority	$2,390,723,000	$2,628,766,000	$2,706,809,000	+$316,086,000	+$ 78,043,000
Reimbursement	$436,394,000	$475,501,000	$504,685,000	+$68,291,000	+$29,184,000
Diabetes 1/	30,000,000	100,000,000	100,000,000	+70,000,000	-0-
Total, Program Level	$2,857,117,000	$3,204,267,000	$3,311,494,000	+$454,377,000	+$107,227,000

1/ The Balanced Budget Act of 1997 transfers $30,000,000 annually to IHS for diabetes prevention and treatment from FY 1998 through FY 2002. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 provided an additional $70,000,000 in FY 2001 and FY 2002, and $100,000,000 for FY 2003.

United States Government and Indian Nations

The provision of Federal health services to American Indians and Alaska Natives (AI/AN) is based on a special relationship between Indian tribes and the United States provided by Article I, Clause 8, of the United States Constitution. Numerous treaties, statutes, and court decisions first expounded in the 1830's by the U.S. Supreme Court under Chief Justice John Marshall have reconfirmed this relationship. Principal among these is the Snyder Act (25 U.S.C.) of 1921 that provides the basic authority for most health services provided by the Federal Government to AI/AN.

In order to develop stronger partnership between the government and tribal governments, the Department of Health and Human Services and IHS have conducted regional meetings with tribes on an annual basis since 1995. The meetings fostered new partnerships between the government, state, and tribes to meet the health needs of Indian people.

The Indian Health Service and Its Partnership with Tribes

For more than 120 years, the responsibility of AI/AN health care passed among different government branches. In 1955, the responsibility for providing health care to AI/AN was officially transferred to the Public Health Service (PHS).

In the 1970's, federal Indian policy was re-evaluated by the Nixon Administration, and the Indian self-determination policy was adopted. This policy emphasizes tribal administration of Federal Indian programs, including health care. Self-Determination does not lessen any federal treaty obligation, but provides an opportunity for tribes to assume the responsibility of providing health care for their members.

The Indian Self-Determination and Education Assistance Act of 1975, as amended, and the Indian Health Care Improvement Act of 1976, as amended, gave new opportunities and responsibilities to the IHS and tribes in delivering care. These included specific authorizations for providing health care services to Indian urban populations, an Indian health professions program, and the ability to collect from Medicare/Medicaid and other third party insurers. Under the Indian Self-Determination Act, many

tribes have assumed the administrative and program direction roles that were previously carried out by the Federal government. Tribes through Self-Determination contracts or Self-Governance compacts administer over one-half of IHS resources. IHS facilities and providers for the direct provision of services to AI/AN utilize the remaining resources where tribes have elected not to contract or compact their health program at this time, and to purchase care from private health care providers and facilities.

To continue strengthening the federal-tribal partnership, IHS implemented a new budget formulation procedure for FY 1999 integrating the Government Performance and Results Act (GPRA), Public Law 93-638, and annual budget formulation into an iterative process that gives local I/T/U more opportunities for annual budget policy input and review. This process was continued in developing the FY 2002 budget request. Work sessions in all 12 Areas initiated the FY 2002 formulation process and established the health priorities with associated budget priorities on which the FY 2002 budget is based.

The Mission, Goal, and Vision

The mission of the agency is to raise the physical, mental, social, and spiritual health of AI/AN to the highest level, in partnership with the population served.

The Director of the IHS has articulated a vision for the Agency on an annual basis. The IHS vision is to continue to be the best primary care, rural health system in the world. A system that, with tribes, continues its goal of assuring that comprehensive, culturally acceptable personal and public health services are available and accessible to the service population. To reach its goal, the clinical program is made up of many separate activities including maternal and child health; fetal alcohol syndrome; diabetes; alcoholism; mental health; emergency medical services; community health representatives; hepatitis B; dental services; and many others. These programs possess curative and preventive components to a degree unparalleled in any similar program. In addition to these clinically based programs, the Agency also encourages a community based environmental health program, sanitation facilities construction program and health facilities construction program.

The IHS program is delivered to a service population of more than 1.5 million AI/ANs through 153 Service Units composed of 568 direct health care delivery facilities, including 49 hospitals, 219 health centers, 7 school health centers, and 293 health stations, satellite clinics, and Alaska village clinics. Within this system, Indian tribes deliver IHS funded services to their own communities with over 44 percent of the IHS budget in 13 hospitals, 161 health centers, 3 school health centers, and 249 health stations and Alaska village clinics. Tribes who have elected to retain the federal administration of their health services, or to defer tribal assumption of the IHS program until a later time receive services with about 56 percent of the IHS budget in 36 hospitals, 58 health centers, 4 school health centers, and 44 health stations. The range of services includes traditional inpatient and ambulatory care, and extensive preventive care, including focused efforts toward health promotion and disease prevention activities.

In addition, various health care and referral services are provided to Indian people in off-reservation settings through 34 urban programs. Another integral part of the program is the purchase of services from non-IHS providers to support, or in some cases in lieu of, direct care facilities. This Contract Health Services program represents approximately 17 percent of the IHS Budget. The IHS Fiscal Intermediary in FY 2000 processed claims at a total billed amount of $434.5 million. The total paid amount after contract and alternate resource savings was $181 million.

Service Units

Service Units, local administrative units, serve a defined geographic area and are usually centered on a single federal reservation in the continental United States, or a population concentration in Alaska. Within these 153 administrative units, health care is delivered through 219 health centers, 7 school health centers, 123 health stations, 170 Alaska village clinics, and 49 hospitals by tribally and federally operated Indian health programs.

Area Offices

Twelve Area Offices provide resource distribution, program monitoring and evaluation activities, and technical support to all operations whether IHS direct or tribally operated. They serve to support the Service Units and their points of service delivery.

Headquarters

The Headquarters operation are determined by statutes and administrative requirements set forth by the Department of Health and Human Services, the Administration, the Congress, and field operations (Area Offices and Service Units). Headquarters is involved with the Department in formulating and implementing national health care priorities, goals, and objectives. It is involved with the Administration through the Department in budget and legislative formulation, responding to congressional inquiries, and appropriate interaction with other governmental entities. It provides Area Offices and Service Units with general program oversight and direction, policy formulation, and resource distribution. It provides expert technical expertise, maintains national statistics, and project trends and needs for the future.

ACCOMPLISHMENTS

Since its inception in 1955, the IHS has demonstrated the ability to effectively utilize available resources to improve the health status of the AI/AN people. With the funding appropriated between 1988 and 1997, dramatic improvements in mortality rates were realized including:

- Infant mortality reduced 30 percent
- Years of Potential Life Lost decreased 17 percent
- Overall mortality reduced 20 percent
- Maternal mortality reduced 33 percent
- TB mortality rate reduced 53 percent

It is indeed discouraging that recent mortality data (FY 1997) available from the National Center for Health Statistics show a small upward trend in the deaths of AI/AN people since FY 1995 from cancer (all), lung cancer, heart disease, and suicide.

During the past 5 years major strides have been made in reducing traumatic injury among American Indians through the implementation of a broad array of public health measures. These measures include injury surveillance; extensive training for community health practitioners, board-based community coalitions and implementation targeted interventions. A recent analysis of injury deaths indicates a significant downward trend in unintentional injury mortality. For instance, the Navajo Nation motor vehicle deaths have been reduced by almost 40 percent. The IHS Injury Prevention Program Plan describes the necessity of building basic tribal capacity in order to institutionalize change. Injury Prevention is one of the Agency's key health initiatives. Since 1997, IHS has fostered the development of tribal injury prevention programs toward identifying community-specific injury patterns and in implementing targeted injury intervention projects. Annually, more than 300 tribal health and IHS personnel are trained in injury prevention practitioner skills. These people are working in their communities to reduce the incidence of severe injury and death. Although significant progress has been made, much more could be done to reduce the major burden on the health and well being of Indian communities. Even today, many reservations experience injury death and disability at rates 2-5 times higher than other Americans do. The right programs are in place and this successful model could be expanded to other tribes.

In fulfillment of the federal policy to afford Indian tribes the right to control the health care programs serving AI/AN, IHS and Indian tribes negotiated 48 self-governance compacts and 67 annual funding agreements, which will transfer approximately $642 million to 217 tribes in Alaska and 49 tribal governments in the lower 48 States under the Self-Governance Demonstration Project in FY 2001.

The IHS, through a sub-contract, completed an evaluation of four tribal demonstration programs. These sites were authorized under the Indian Health Care Improvement Act to directly bill and collect for Medicaid and Medicare services. Because of the high degree of success, the 106th Congress enacted permanent authority to allow all tribal programs to implement direct billing and collection.

Work on determining an acceptable methodology for measuring health needs of tribes and Indian people was completed in FY 2000 in fulfillment of Congressional direction to IHS. A national tribal work group guided an economic analysis based on actuarial modeling by a health economics firm. Additional technical support was provided by Agency for Health Care Policy and Research staff and IHS staff. The successful conclusion of this project provides the tribal and federal Indian health policy makers with a method of estimating the benefits and costs of the personal medical services for the American Indian population in comparison to a mainstream health benefit package available through the Federal Employees Health Benefit Program (FEHBP).

The IHS successfully conducted extensive consultation with Indian tribes on the distribution of $80 million in new funding appropriated for Contract Health Services and the Indian Health Care Improvement Fund in FY 2001.

Final agency decisions on the distribution of these new program funds will occur by the end of March 2001 and allotment of funds to each of the 12 areas will take place in April 2001. Another $30 million in new Alcohol and Substance Abuse funding will be targeted to prevention activities at the village level in Alaska Area, and, in the other 11 IHS areas, to address data improvement along with the youth and women acute treatment.

In 2001 and 2002, the IHS will continue to focus on strengthening business office management practices including provider documentation training, procedural coding, processing claims and information systems improvements. In FY 2000, IHS wide efforts were initiated to improve each hospital's capability to identify patients who are eligible or may become eligible for third party reimbursement. A major part of this initiative includes the identification of all children who may be eligible for participation in the Children's Health Insurance Program (CHIP). For 2001 and 2002, the IHS will continue working with HCFA and the State Medicaid Offices to help ensure the success of this effort.

Special Concerns

Within the vast IHS program, there are certain categories of health conditions that are of special concern in FY 2002. Specific disease entities identified as priority areas by the I/T/U and responsible for much of the health disparities in health status for AI/AN population are targeted by the proposed budget request through the Indian Health Care Improvement Fund. These include dental diseases, injuries, mental health, alcoholism, and cancers. Investments in public health infrastructure and information systems are also included in the request. The Agency budget supports priority activities designed to increase the capacity to address the top health concerns identified by the Indian tribes and serve the needs of the most vulnerable segments of the AI/AN population including: children, women and elders.

Health care and related facilities construction are another priority essential to assuring further progress in preventing infectious diseases and improving the quality of life.

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